JAMES
BIENEMAN, D.D.S.
303-797-0832 www.bienemandentistry.com
6650 South Vine Street, Suite 220, Centennial, CO 80121

Patient Registration

Patient's Name: Date of Birth:

Home address:

City: State: Zip:

Home Phone. # Cell Phone. #

Your Employer: Work Phone. #

Soc. Security #: E-mail address:

Marital status: Single Married Widow Separated

Are you a full time student?

If patient is a minor, we need: Mother's DOB: Father's DOB:

Responsible Party Name:

Relationship: Spouse's/Parents: Soc Security #

Driver's License #: Spouse's/Parent's Phone #:

Emergency Contact name, address and telephone of a relative not living with you:

Dental Insurance information (Primary)	If you have secondary insurance
Insured's Name:	Insured's Name:
Insured's Employer:	Insured's Employer:
Insurance Company:	Insurance Company:
Phone #:	Phone #:
DOB:	DOB:
SS#:	SS#:
Group #:	Group #:
ID number#:	ID number#:

Patient's Signature (Parent if a minor) Date

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Child's Name: _____ Date of Birth: _____
Child's Primary Care Doctor: _____
Prescription Medications: _____
Herbs/Home Remedies: _____
Allergies: _____

Has your child had any speech issues? _____
Has your child had any feeding/dietary problems(i.e. texture issues, loud, messy eater, picky)? If so, what? _____

Past Medical History

Does your child have conditions related to any of these symtoms? If so please explain below

	Yes	No		Yes	No
Lung	○	○	Developmental Concerns/Learning problems	○	○
Heart	○	○	Histroy of ear infections?	○	○
Kidney/Urinary	○	○	ADHD	○	○
Bone/Muscles	○	○	Asthma	○	○
Gastro-intestinal	○	○	Genital	○	○
Eating Disorders	○	○	Ear/Nose/Throat/Eye	○	○
Brain/Nervous System	○	○	Behavioral Problems	○	○
Diabetes	○	○	Cold Sores/Fever Blisters	○	○
Cancer	○	○			

Social History

Frequently Tired	○	○	Bed Wetting	○	○
Snore	○	○	Mouth Breather	○	○
Regular Heachaches	○	○	Jaw clicking or popping	○	○
Hard to Wake up	○	○	Gag easily	○	○
Grind their teeth	○	○	Suck their thumb, fingers, heair, etc.?	○	○

If "Yes" please explains: _____

Are there any other medical conditions or concerns: _____

_____ _____ _____
Parent signature Date Dentist Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship
_____	_____
{Please Print Name}	Relationship

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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Financial Policy

Thank you for choosing us as your dental care provider. Our office is committed to providing you with the best possible care. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. All patients must complete our Information and Insurance form before seeing the doctor.

Regarding Payment

Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and the billing receptionist.

If dentures, partial dentures, crown and bridge are to be fabricated by a dental laboratory, a 50% deposit will be required at the time of the first impression. The remaining balance is due at the time the prosthesis is cemented or inserted.

The parent that accompanies the minor child/children to the appointment is responsible for any payment due. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized before the appointment date or previous arrangements have been made with the doctor and billing receptionist.

Checks that are returned to our office from your financial institution are subject to a $20.00 returned check fee. This fee covers the processing fees that are charged to our office.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Your **estimated** co-payment for treatment, which is the amount not covered by your insurance, is due at the time service is provided. Your co-payment may be adjusted after the time of service depending upon the final reconciliation of insurance payments. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through CareCredit upon request and approval.

You will have to take responsibility for any fees your insurance has not covered after 60 days. Any expenses incurred in collecting a past due account will be turned over to a collection agency after 90 days which can include attorney fees.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

Signature of Patient or Responsible Party: _____ Date: _____